File

Commonwealth of Virginia

COUNTY OF FAIRFAX

4110 CHAIN BRIDGE ROAD, ROOM 114
FAIRFAX, VIRGINIA 22030-4047

RAYMOND F. MORROGH
COMMONWEALTH'S ATTORNEY
IAN M. RODWAY
CHIEF DEPUTY COMMONWEALTH'S ATTORNEY
JOHN R. MURPHY
DEPUTY COMMONWEALTH'S ATTORNEY
KATHERINE E. STOTT
DEPUTY COMMONWEALTH'S ATTORNEY
CASEY M. LINGAN
DEPUTY COMMONWEALTH'S ATTORNEY
703-246-2776

KATHRYN S. SWART
JOHN J. MURRAY
GREGORY O. HOLT
MARC J. BIRNBAUM
MARK J. SULLIVAN
CAMILLE TURNER
KELLY K. PEARSON
ROBERT D. MCCLAIN
KATHRYN A. PAVLUCHUK
BRANDON R. SHAPIRO
ERIN L. SYLVESTER
JAMES PANAGIS
DYLAN S. GALLAGHER
J. DAVID GARDY
MICHAEL M. GROMOSAIK
JEREMY S. BALINT
MARK J. OBERNDORF
JONATHAN L. PHILLIPS
ELIZABETH H. NASH
JILL T. TAYLOR
JESSICA L. GREIS EDWARDSON
CRISTIN G. HEAD
ASSISTANTS

December 16, 2009

Guillermo Uriarte, Esq.
5881 Leesburg Pike, Suite 402
Falls Church, Virginia 22041

Re: *Commonwealth v. Trudy Eliana Munoz Rueda. Trial: Jan 11- 13, 2010*

Dear Mr. Uriarte:

Enclosed please find the following documents for your review:

1. Medical records from Fairfax INOVA Hospital regarding treatment of the victim [redacted] (Includes CT and MRI Scans)
2. Dr. William E. Hauda II - Pediatric Physical Abuse Evaluation Report
3. Medical Records from Children's Medical Center – Ophthalmology Department (Includes retinal scans)
4. Medical Report from The Wilmer Eye Institute
5. Medical Records from victim's Pediatrician (Kidz Doc)
6. Prenatal Records for [redacted] and his mother
7. Birth Records for [redacted]

The remaining non-medical related documents will be provided per the discovery order entered in this case. Per our phone conversation, it is my understanding that you do not require the appearance of the custodian of records for the authenticity of the medical records and do not object to the admissibility of these documents as evidence.

Sincerely,

Gregory O. Holt
Assistant Commonwealth's Attorney

CC: Court/file

4250618
11/29/08 to
12/1/08 ER

HealthPort
Med. Records

PT

1301

Patient Name [redacted]
Social Security# (Optional)
Dates of Service [redacted] 08 - [redacted] 08
Medical Record Number
Patient Date of Birth [redacted] 08
Contact Phone Number 571-332-1201
Patient Address [redacted] Alexandria VA [redacted]
City State Zip Code
Guarantor

To release or disclose the following information to: Physician Phone # (required if records are to be faxed)
Evin Whitmer Fax #
Name of person or entity to receive information For physician or patient only
[redacted] Alexandria VA [redacted]
City State Zip Code

Information to be released/disclosed

- ☐ Emergency Room Record
- ☐ Face Sheet
- ☑ Discharge Summary
- ☑ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Preoperative Admit Note
- ☐ Psychiatric Evaluation
- ☐ Progress Notes
- ☐ Physician Orders
- ☐ Radiology Reports
- ☐ Radiology Films(CD)
- ☑ Laboratory Reports
- ☐ EKG/EEG
- ☐ Substance Abuse Records
- ☐ Part of Current Home Health
- ☑ Complete Health Record
- ☐ Record Analysis
- ☐ Billing Information
- ☐ Other

Purpose:

- ☐ Medical Follow-Up
- ☑ Attorney
- ☐ Insurance
- ☐ Other

Patient advised of charges: ☑ Yes ☐ No ☐ N/A

- ☐ Release the records
- ☐ I wish to review the records
- ☐ Fax to the number above
- Note: You will need to make an appointment for the review
- ☑ Will pick up the records

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that revocation of authorization is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I understand that my revocation will not be effective as to disclosures already made in reliance on this authorization.

I understand Inova Health System may not condition treatment on my decision to sign this authorization.

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

Evin M Whitmer — Signature of Patient or Representative
8/24/09 — Date (Authorization will expire six months after date signed)
Evin M. Whitmer — Print Name of Personal Representative (If applicable)
Mother — Relationship to Patient

INOVA HEALTH SYSTEM

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

04/14 (04/07)
Page 1 of 1

PATIENT LABEL
Inova Alexandria Hospital
Date: 9/9/09 Req #: 20533445
ABS ER DS HP XRY
EKG CON LAP OP REPORT
PATH ENTIRE RECORD
Other
Scanned # Pages
Initials DM

MED0010

INOVA HEALTH SYSTEM

Requested by: PURKERT, KATHERINE

Patient	:W[redacted] N[redacted] G.
MRN	:04306493
DOB	:[redacted]2008
Date of Service	:
Performing Facility	:FH
Ordering Provider	:
Result Provider	:
Report Name	:CONSULTATION REPORT
Status	:P TRX X

PHYSICAL EXAMINATION: EEG is being taken at this time. Head is wired and wrapped. Heart rate 115, respiratory rate 34, saturation 99%. Patient is not tracking at this time, but eyes are open. The patient is alert. Patient is scanning around purposely when he is spoken to. His face is symmetric. He smiled briefly and he also cried and whimpered a lot, particularly at dad when dad was talking to him. Whenever dad got close and started talking with him, he would coo back at him as if he wanted to be picked up, and he reached his hands in his general direction. He was moving all 4 extremities, left side slightly better than the right side, but he was demonstrating distal and proximal movement that is actually nonpatterned looking and did not look spastic. He appeared to isolate finger movement, able to grab my fingers when they were put in his hands and demonstrated flexion and extension of all major joints. He dorsiflexed, planter flexed ankles and extended and flexed the knees. He had dressings and things on his right leg, which limited the movement on that side, appeared to have slightly brisk reflexes on the right compared to the left. He did not have clonus. Passive range of motion is excellent in the upper and lower extremities.

ASSESSMENT AND PLAN: A 4-month-old boy previously healthy, presenting 04/20/2009, with seizures, nonaccidental trauma, status epilepticus, retinal hemorrhages, subdural hematoma without major mass effect, just extubated today. Cranial CT shows subdural hematoma but no definitive parenchymal injury (MRI is not yet done), though the seizures suggest some injury.

1. On exam, shows impaired vision (____ explained by severe retinal hemorrhages) but patient actually does move all extremities, including good distal fine motor bilaterally, the left-sided movement slightly greater than right; good level or arousal with responsive reactive cooing and whimpering as dad talks up close to him, grabs my fingers and pulls, all positive signs.
2. Recommend speech and swallow evaluation given stridor and encephalopathic at this time, coming off intubation, sedation, and traumatic brain injury, aspiration risk.
3. Physical therapy and occupational therapy initiated shortly.
4. Discussed findings with dad, family at bedside, clearly improving.

INOVA HEALTH SYSTEM

Requested by: PURKERT, KATHERINE

Patient :[redacted], N[redacted] G.
MRN :04305493
DOB :[redacted]2008
Date of Service :
Performing Facility :FH
Ordering Provider :
Result Provider :
Report Name :CONSULTATION REPORT
Status :P TRX X

DATE OF BIRTH: [redacted]2008.
ADMISSION DATE: 04/20/2009

PATIENT LOCATION: W6N W51601

DATE OF CONSULTATION: 05/01/2009
CONSULTANT: John S Myseros. MD
CONSULTING SERVICE: PEDIATRIC NEUROSURGERY

I have been asked to see this little boy before he is discharged home. This is essentially a 5-month-old little boy who was admitted to the hospital with a nonaccidental injury. Evidently, he presented on 04/20/2009 with seizures. A CT scan upon admission showed multiple areas of blood and some swelling with poor gray/white differentiation. He was subsequently found to have retinal hemorrhages and was diagnosed with a nonaccidental injury. He just had an MRI prior to his planned discharge: it showed some subdural collection, so I was called. I have not formerly examined the little boy other than feeling his fontanel. When he is not crying, his fontanel is quite soft. When he is crying it is a little more full. There is no _____. He does have a feeding tube in, unremarkable

I spent some time talking to his family and reviewing the MRI. There are areas of injury bilateral occipital lobes, as well as the left parietal lobe. There is a subdural hygroma more on the left than on the right. There is significant volume loss with cerebral atrophy. The cortical sulci are well defined and the ventricles are getting larger.

I have explained to the family that I do not believe this is hydrocephalus but rather atrophy of the brain and the development of subdural collections because his brain is essentially shrinking. These children can get hygromas that lead to head growth acceleration and sometimes need to be tapped. On rare occasion, they even need to be shunted. We refrain any subdural taps or any invasive procedures unless there is evidence of head growth acceleration or clinical evidence of increased intracranial pressure, such as lethargy, sunsetting eyes or unexplained vomiting.

If this child is well, I would like to see him back in the neurosurgery office in 3 to 4 weeks. I have given his parents my card.

Thank you for allowing me to see this young man.

98928

PEDIATRIC (Birth-12 years) ADMISSION HISTORY AND PHYSICAL EXAM

Social History (include parental/ sibling age, parental occupation(s))	lives c parents and dad c sinusitis dad works IT	
Family History	___ HTN ___ CAD ___ Asthma ___ Diabetes ___ Cancer ___ VUR X Congenital Anomalies X Learning Disabilities ___ Other MR- died age 8 (chromosomal disorder) PGF → febrile seizures, paternal cousins → Muscular dystrophy	

Review of Systems

CONST:	☐ ~~Fever~~	☐ Chills	☐ Diaphoresis	☐ Weight Change
EYE:	☐ Redness L/ R	☐ Pain L/ R	☐ Discharge L/ R	☐ Vision Change L/ R
ENT:	☐ Hearing Changes	☐ Sore Throat	☐ ~~Earache~~	☐ Epistaxis
RESP:	☐ SOB	☒ Cough	☐ ~~Sputum~~	☐ Hemoptysis
CV:	☐ Chest Pains	☐ Palpitations	☐ Edema	☐ DOE
GI:	☐ Abdominal Pain	☐ Nausea	☐ ~~Vomiting~~	☐ ~~Diarrhea~~
GU:	☐ Frequency	☐ Dysuria	☐ Hematuria	☐ Bleeding
MS:	☐ Myalgias	☐ Arthralgias		
SKIN:	☐ Rash	☒ Bruising	☐ Lesions	☒ **ALL OTHER SYSTEMS REVIEWED WERE NEGATIVE**
NEURO:	☐ Weakness	☐ Numbness	☐ Dizzy	
PSYCH:	☐ Depression	☐ Anxiety	☐ Suicidal	
ENDO:	☐ Polyuria	☐ Polydipsia		
DOM VIOL:	☐ Safe in current environment			

PHYSICAL EXAMINATION

Vital Signs	Temp	P	RR	BP	POx	Weight / %	Hgt or Lgth / %	Wt for Lgth or BMI / %	HC ≤ 2 yrs / %
	98.3	170	28	98/58	100% ETT 3.5	6.8kg 50%	65cm 50%		43.5cm 50-75%

General Condition	intubated, sedated, NAD
HEENT	nmm PERRL eyes closed 2mm pupils
Neck	supple
Cardiovascular	RRR S1S2 no m/r/g 2+ femoral pulses
Respiratory	ventilated breaths CTAB
Abdomen	soft NTND NABS no HSM

PATIENT IDENTIFICATION

W[redacted]
N[redacted]
04305493 PADM
4 m M ADM
G[redacted]/2008
FH 37373672
ACCT STRT 4/20/2009

INOVA FAIRFAX HOSPITAL FOR CHILDREN
PEDIATRIC HISTORY

INOVA FAIRFAX HOSPITAL
PRIMARY

W[redacted] N[redacted] G
DOB: [redacted] 2008 M4M
Wt/Ht: 6.8 Kg
MedRec: 04305493
AcctNum: 37373672

HPI TRAUMA

CHIEF COMPLAINT: Patient presents for the evaluation of ?**"choking/seizing"**. (15:29 SDH)
HISTORIAN: History obtained from parent, History obtained from EMS. (15:29 SDH)
MECHANISM: Complaint occurred by **unknown**. (15:29 SDH)
OCCURRED: Onset was **this PM, Patient currently has symptoms**, Occurred at daycare. (15:29 SDH)
NOTES: **4 mo M with no significant PMH BIBA p/w questionable choking/sz onset this PM while pt was at daycare. Per EMS, babysitter gave a few rescue breaths and comrpressions. +sz.**
A)patent B)BBS C)BP:102/58, HR:165 D)GCS=3 E)yes. (15:57 SDH)

ROS (16:13 KDOL)

CONSTITUTIONAL PED: No fever, No fussiness.
RESPIRATORY PED: No cough.
GI PED: No vomiting, No stool changes.
NOTES: All systems were reviewed and are negative for acute complaints except as described above.

PHYSICAL EXAM (16:21 KDOL)

CONSTITUTIONAL PED: Triage vital signs reviewed, Appears well hydrated, **actively seizing**.
HEAD PED: Atraumatic, Normocephalic, **Fontanel mildly bulging**.
EYES: **eyes deviated to RIGHT, pupils sluggish to react**.
ENT PED: Ears and nose normal to inspection, Oropharynx normal, Tympanic membranes normal.
NECK PED: Trachea midline, No masses.
RESPIRATORY CHEST PED: Breath sounds clear and equal bilaterally, **mild suprasternal retractions.**
CARDIOVASCULAR PED: RRR, Heart sounds normal.
ABDOMEN PED: Abdomen is soft, No distension, No masses.
GENITOURINARY MALE PED: External genitalia normal.
BACK: Normal inspection.
UPPER EXTREMITY: Inspection normal, No edema.
LOWER EXTREMITY: Inspection normal, No edema.
NEURO PED: **Pt actively seizing.**
SKIN: Skin is dry, Skin is normal color.
LYMPHATIC: No adenopathy in neck.

INTUBATION (15:46 CDAR)

INTUBATION: Emergent consent implied, Performed by resident, I was present for the entire procedure, Patient's airway is patent, **Patient being ventilated with bag valve mask, Airway suctioned,** Indication for intubation is respiratory failure, Oral-laryngoscopy intubation used, Patient sedated with benzodiazepine, Paralytic used: vecuronium, Patient was pre-oxygenated, Size of tube used is 3.5, Tube is cuffed, in 1 attempt, Tube visualized through cords, Breath sounds equal after intubation, OGT placed, Qualitative end tidal CO2 reading taken and confirms endotracheal intubation, Breath sounds heard bilaterally, no gurgling heard over epigastrium, Chest x-ray ordered to confirm placement, Patient tolerated procedure well, **Dr. Thorton at bedside for entire procedure**.

NGT/OGT (15:48 CDAR)

TIME OUT: Attending Name: Thorton.
NGT/OGT: Emergent consent implied, Performed by resident, I was present for the entire procedure, Nasogastric tube placement indicated for airway management, in the oropharynx, Description of output: Clear secretions returned, NG tube inserted after 1 attempt, Tube was clamped, No complications noted, Patient tolerated

Date / Time: 5/8/09 1500
Weight (kg) 7kg ☐ actual ☐ reported ☐ estimated ☐ ideal ☐ adjusted
Height (cm) _____ BSA (m²) _____ (√Ht (cm) x Wt (kg) / 3600)

Allergies: Medication / Food Reaction

☑ None

MEDICATION LIST (REPLACES ALL PREVIOUS MEDICATION LISTS): ☐ No Home Medications

Medication Name	Concentration / Strength*	Dose	Frequency	Route	Last Given	Indication
Phenobarbital	6mL	by mouth	every 12 hrs			seizures
Diastat	one gel	per rectum	every 12 hrs			for active seizures as needed
Methadone Valium	see attached	schedule				
Fer-In-Sol	1 mL	by mouth	once daily			anemia
★ See attached						

DO NOT TAKE ANY OTHER MEDICATIONS WITHOUT CONTACTING YOUR DOCTOR

Special Instructions: For any seizure, use diastat x 1 then call your doctor / 911

Tablet/capsule size (ie, micrograms, mg, gm) or liquid/suspension/injection concentration (ie, mg, units/mL)
At discharge, if a concentration to be formulated is unobtainable, the mg amount MUST be part of the medication column

MD Amanda Selm MD (reconciled with admit MRS) Selden (print) 66102 (beeper) RN _____ (reviewed with parent prior to discharge)

Parent/Guardian Signature: X Erin Whetmore

PATIENT IDENTIFICATION

W[redacted] N[redacted] G[redacted]08
04305493 5M M FH 37373672
PADM ADM 04/20/09 ACCT STAT

INOVA HEALTH SYSTEM
DISCHARGE-PEDIATRIC MEDICATON RECONCILIATION SHEET

CAT # 85658 / R110906 · PKGS OF 100

BLOOD CULTURES (Continued)

NO GROWTH 5 DAYS
DATE AND TIME OF REPORT: 05/01/2009 AT 1001

** Sputum Culture 26APR2009 01:44 MCRO Final

W[redacted] N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

CULTURE, SPUTUM
TRACHEAL ASPIRATE
ACCESSION #: MM-09-039436
COLLECTED: 04/26/09 AT 0144
RECEIVED: 04/26/09 AT 0305

STAINS AND PREPARATIONS
04/26/09 0348
RARE WBCS
NO ORGANISMS SEEN
FINAL REPORT
04/27/09 1317
MODERATE GROWTH OF STREPTOCOCCUS PNEUMONIAE
LIGHT GROWTH OF STAPHYLOCOCCUS AUREUS
REFER TO PREVIOUS SUSCEPTIBILITY RESULTS
DATE AND TIME OF REPORT: 04/27/2009 AT 1319

** Sputum Culture 20APR2009 23:42 MCRO Final

W[redacted] N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

CULTURE, SPUTUM
TRACHEAL ASPIRATE
ACCESSION #: MM-09-037895
COLLECTED: 04/20/09 AT 2342
RECEIVED: 04/21/09 AT 0029

STAINS AND PREPARATIONS
04/21/09 0106
FEW WBCS
MANY GRAM POSITIVE COCCI
FEW GRAM POSITIVE RODS
RARE GRAM NEGATIVE RODS
FINAL REPORT
04/24/09 1406
HEAVY GROWTH OF STAPHYLOCOCCUS AUREUS AND STREPTOCOCCUS PNEUMONIAE
SUSCEPTIBILITY TESTING

S AUREUS	MIC	INTERP
AZITHROMYCIN		S
CIPROFLOXACIN	<=0.5	S
CLINDAMYCIN	<=0.25	S
D-TEST	NEGATIVE	
ERYTHROMYCIN	<=0.25	S
LEVOFLOXACIN	<=0.12	S
OXACILLIN	0.5	S
SULFA/TRIMETH	<=10	S
TETRACYCLINE	<=1	S
VANCOMYCIN	<=0.5	S

S PNEUMO	MIC	INTERP
AMPICILLIN		S

INOVA HEALTH SYSTEM

Requested by: BARNES, CONNIE

Patient	:[redacted] G.
MRN	:04305493
DOB	:[redacted]/2008
Date of Service	:
Performing Facility	:FH
Ordering Provider	:MABROUK, SUSAN
Result Provider	:
Report Name	:Chest Single View Portable
Status	:F DXSTIC X

Chest Single View Portable - STATUS: Final
IMAGE By: Lee Dr., John H, Perform Date: 29Apr09 05:20
Ordered By: Mabrouk Dr., Susan M, Ordered Date: 29Apr09 00:36
Facility: FH Department: DXR

Service Report Text
EXAMINATION: DX3-0213 CHEST 1 VW PORTABLE
Date of Service: 04/29/2009 05:20

INTERPRETATION:

HISTORY: 5-month-old boy with intubation.

COMPARISON: 4/27/2009

FINDINGS: ET tube is 1.3 cm above the carina. There slight prominence of perihilar markings on the right with increased right lobe atelectasis. There is no pleural effusion. The left lung is clear. The cardiomediastinal silhouette is normal. Corpak tip is in the proximal duodenum.

IMPRESSION: Increased right upper lobe atelectasis.

Dictating Physician: JOHN LEE M.D.
Electronically Signed: 012962 on Apr 29 2009 1:19PM
Dictated: Apr 29 2009 1:20PM
Transcribed: on Apr 29 2009 1:19PM

INOVA HEALTH SYSTEM

Requested by: BARNES, CONNIE

Patient	[redacted], N[redacted] G.
MRN	04305493
DOB	[redacted]/2008
Date of Service	
Performing Facility	FH
Ordering Provider	MABROUK, SUSAN
Result Provider	
Report Name	Chest Single View Portable
Status	F DXSTIC X

Chest Single View Portable - STATUS: Final
IMAGE By: Schneider Dr., Ingrid
Ordered By: Mabrouk Dr., Susan M.
Facility: FH

Perform Date: 25Apr09 06:29
Ordered Date: 25Apr09 00:43
Department: DXR

Service Report Text
EXAMINATION: DX3-0213 CHEST 1 VW PORTABLE
Date of Service: 04/25/2009 06:29

INTERPRETATION:

Clinical History: Assess ET tube position

Comparison: 4/24/2009

Portable Chest: The endotracheal tube projects 1.5 cm above the carina. The Corpak projects to the duodenal bulb.

The heart is normal in size. The lungs demonstrate diffuse interstitial abnormality and more pronounced perihilar opacities, more pronounced right upper lobe atelectasis is suggested. There is no effusion. No pneumothorax.

IMPRESSION: Persistent pulmonary opacities. satisfactory position of tubes and lines as described.

Dictating Physician: INGRID SCHNEIDER M.D.
Electronically Signed: 010691 on Apr 25 2009 9:03AM
Dictated: Apr 25 2009 9:04AM
Transcribed: on Apr 25 2009 9:03AM

INOVA HEALTH SYSTEM

Requested by: BARNES, CONNIE

Patient	:[redacted] G.
MRN	:[redacted]
DOB	:[redacted]2008
Date of Service	:
Performing Facility	:FH
Ordering Provider	:PADUA, ERIC
Result Provider	:
Report Name	:Chest Single View Portable
Status	:F DXSTIC X

Chest Single View Portable - STATUS: Final
IMAGE By: Jerath Dr., Nakul . Perform Date: 26Apr09 05:38
Ordered By: Padua Dr., Eric M. Ordered Date: 26Apr09 03:42
Facility: FH Department: DXR

Service Report Text
EXAMINATION: DX3-0213 CHEST 1 VW PORTABLE
Date of Service: 04/26/2009 05:38

INTERPRETATION:

HISTORY: Assess ET tube. Traumatic subdural.

COMPARISON: 4/25/2009.

FINDINGS: ET tube extends to the distal trachea and enteric tube extends to the proximal duodenum. Lung volumes are diminished. There is right greater than left perihilar, right upper lobe and right infrahilar opacities, which are more pronounced. Heart size is accentuated. There is no pneumothorax.

IMPRESSION: Progressed airspace opacities. No pneumothorax.

Dictating Physician: NAKUL JERATH M.D.
Electronically Signed: 002125 on Apr 26 2009 8:40AM
Dictated: Apr 26 2009 8:41AM
Transcribed: on Apr 26 2009 8:40AM

INOVA HEALTH SYSTEM

Requested by: BARNES, CONNIE

Patient	:W[redacted] M[redacted] G.
MRN	:04305493
DOB	:[redacted]/2008
Date of Service	:
Performing Facility	:FH
Ordering Provider	:THORNTON, DAWN
Result Provider	:
Report Name	:Chest Single View Portable
Status	:P DXSTIC X

Chest Single View Portable - STATUS: Prelim
IMAGE By: Jerath Dr., Nakul . Perform Date: 20Apr09 16:34
Ordered By: Thornton Dr., Dawn M. Ordered Date: 20Apr09 15:39
Facility: FH Department: DXR

Service Report Text
EXAMINATION: DX3-0213 CHEST 1 VW PORTABLE
Date of Service: 04/20/2009 16:06

INTERPRETATION:

HISTORY: Cardiac arrest.

COMPARISON: None.

FINDINGS: ET tube extends to the distal trachea. Enteric tube extends to the stomach. Heart size is within normal limits. Hazy bilateral pulmonary opacities are seen. This could represent patchy atelectasis or infiltrate. There is no pneumothorax.

IMPRESSION: Question patchy bilateral atelectasis versus infiltrate. No pneumothorax.

Dictating Physician: NAKUL JERATH M.D.
Electronically Signed: 002125 on Apr 20 2009 4:32PM
Dictated: Apr 20 2009 4:33PM
Transcribed: on Apr 20 2009 4:32PM

INOVA HEALTH SYSTEM

Requested by: BARNES, CONNIE

Patient	:W[redacted] N[redacted] G.
MRN	:04305493
DOB	:[redacted]/2008
Date of Service	:
Performing Facility	:FH
Ordering Provider	:THORNTON, DAWN
Result Provider	:
Report Name	:CT Head-Brain WO Contrast
Status	:F DXSTIC X

CT Head-Brain WO Contrast - STATUS: Final
IMAGE By: Goldstein Dr., Brian S Perform Date: 20Apr09 15:55
Ordered By: Thornton Dr., Dawn M, Ordered Date: 20Apr09 15:44
Facility: FH Department: CTS

Service Report Text
EXAMINATION: CT3-0185 CT HEAD BRAIN WO CONT
Date of Service: 04/20/2009 15:55

INTERPRETATION:

HISTORY: Lethargy

FINDINGS:

Noncontrast CT imaging of the head was performed. The study is abnormal. There is increased attenuation ventral to the high left frontal lobe. This appears contiguous with abnormally increased attenuation tracking along the falx in a left parafalcine distribution and along the left tentorium. Findings are suspicious for a subdural hematoma measuring approximately 4 mm in maximum thickness. There is no midline shift or hydrocephalus. The basilar cisterns are clear. No depressed skull fracture is detected. The mastoid, middle ear cavity and paranasal sinus regions are clear.

IMPRESSION:
1. Abnormal head CT demonstrating what appears to be extra-axial blood ventral to the high left frontal lobe, tracking along the left parafalcine distribution and somewhat along the left tentorial leaf as discussed above. Findings are suspicious for a subdural hematoma. Close followup is recommended.

This urgent result was telephoned to the emergency room physician caring for the patient at the time of interpretation.

Dictating Physician: BRIAN GOLDSTEIN M.D.
Electronically Signed: 010969 on Apr 20 2009 4:13PM

4305493 W[redacted] N[redacted] **LABORATORY REPORT** Page 5 (more)
Report ID:LABORATORY REPORT
Terminal ID : FHMR6MC
Reporting period = 20Apr2009 thru 8May2009 Requested by:CONNIE BARNES U65767

	Final	Final
Urine Type		Foley @a1 M
Color	YELLOW	YELLOW

COMMENTS

a1- If a microscopic evaluation is clinically indicated, a new order for 'UA With Microscopic' and a fresh specimen is required.

BLOOD BANK

BLOOD BANK TESTING;
** No data matched **

BODY FLUID ANALYSIS

BODY FLUID ANALYSIS;
** No data matched **

BLOOD GASES

BLOOD GASES;
** No data matched **

CVSL TESTS

CVSL TESTS;
** No data matched **

IMMUNOLOGY

IMMUNOLOGY SECTION;
** No data matched **

MICROBIOLOGY

MICROBIOLOGY;
; MICROBIOLOGY

** RSV Detection 01MAY2009 19:37 MCRO Final

W[redacted], N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

RSV DETECTION
NASAL SWAB

ACCESSION #: VV 09-003878
COLLECTED: 05/01/09 AT 1937
RECEIVED: 05/01/09 AT 2058

FINAL REPORT
05/01/09 2122
NEGATIVE FOR RSV (RESPIRATORY SYNCYTIAL VIRUS) ANTIGEN
DATE AND TIME OF REPORT: 05/01/2009 AT 2123

** Influenza Antigen 01MAY2009 19:37 MCRO Final

W[redacted] N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

INFLUENZA ANTIGEN DETECTION
NASAL SWAB

ACCESSION #: MM-09-041918
COLLECTED: 05/01/09 AT 1937
RECEIVED: 05/01/09 AT 2058

FINAL REPORT
05/01/09 2123
NEGATIVE FOR INFLUENZA A ANTIGEN
NEGATIVE FOR INFLUENZA B ANTIGEN
DATE AND TIME OF REPORT: 05/01/2009 AT 2123

4305493 W[redacted] N[redacted] LABORATORY REPORT Page 6 (more)
Report ID:LABORATORY REPORT
Terminal ID : FHMR6MC
Reporting period = 20Apr2009 thru 8May2009 Requested by:CONNIE BARNES U65767

** Sputum Culture 28APR2009 08:26 MCRO Final

W[redacted] N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

CULTURE, SPUTUM
ENDOTRACHEAL TUBE

ACCESSION #: MM-09-040189
COLLECTED: 04/28/09 AT 0826
RECEIVED: 04/28/09 AT 1024

STAINS AND PREPARATIONS
04/28/09 1345
FEW WBCS
RARE EPITHELIAL CELLS
MODERATE GRAM POSITIVE COCCI
FINAL REPORT
04/30/09 0933
MODERATE GROWTH OF STAPHYLOCOCCUS AUREUS
MODERATE GROWTH OF STREPTOCOCCUS PNEUMONIAE
SUSCEPTIBILITY TESTING WAS NOT REPEATED ON THIS ISOLATE BECAUSE IT WAS PERFORMED ON THE SAME ORGANISM FROM A CULTURE COLLECTED WITHIN 14 DAYS OF THIS ONE
SUSCEPTIBILITY TESTING

S AUREUS	MIC	INTERP
AZITHROMYCIN		S
CIPROFLOXACIN	<=0.5	S
CLINDAMYCIN	<=0.25	S
D-TEST	NEGATIVE	
ERYTHROMYCIN	<=0.25	S
LEVOFLOXACIN	0.25	S
OXACILLIN	0.5	S
SULFA/TRIMETH	<=10	S
TETRACYCLINE	<=1	S
VANCOMYCIN	<=0.5	S

DATE AND TIME OF REPORT: 04/30/2009 AT 0934

** Blood Cult (Aerobic) 28APR2009 05:09 MCRO Final

W[redacted] N[redacted] G

BLOOD CULTURES

CULTURE, BLOOD, AEROBIC
BLOOD OBTAINED BY VENIPUNCTURE

ACCESSION #: BL-09-025412
COLLECTED: 04/28/09 AT 0509
RECEIVED: 04/28/09 AT 0533

FINAL REPORT
05/03/09 0921
NO GROWTH 5 DAYS
DATE AND TIME OF REPORT: 05/03/2009 AT 0921

** Blood Cult (Aerobic) 26APR2009 02:14 MCRO Final

W[redacted] N[redacted] G

BLOOD CULTURES

CULTURE, BLOOD, AEROBIC
BLOOD FROM ARTERIAL DRAW

ACCESSION #: BL 09 024946
COLLECTED: 04/26/09 AT 0214
RECEIVED: 04/26/09 AT 0513

FINAL REPORT
05/01/09 1000

BLOOD CULTURES (Continued)

NO GROWTH 5 DAYS
DATE AND TIME OF REPORT: 05/01/2009 AT 1001

** Sputum Culture 26APR2009 01:44 MCRO Final

W[redacted] N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

CULTURE, SPUTUM
TRACHEAL ASPIRATE

ACCESSION #: MM-09-039436
COLLECTED: 04/26/09 AT 0144
RECEIVED: 04/26/09 AT 0305

STAINS AND PREPARATIONS
04/26/09 0348
RARE WBCS
NO ORGANISMS SEEN
FINAL REPORT
04/27/09 1317
MODERATE GROWTH OF STREPTOCOCCUS PNEUMONIAE
LIGHT GROWTH OF STAPHYLOCOCCUS AUREUS
REFER TO PREVIOUS SUSCEPTIBILITY RESULTS
DATE AND TIME OF REPORT: 04/27/2009 AT 1319

** Sputum Culture 20APR2009 23:42 MCRO Final

W[redacted] N[redacted] G

RESPIRATORY CULTURES AND ASSOCIATED TESTS

CULTURE, SPUTUM
TRACHEAL ASPIRATE

ACCESSION #: MM-09-037895
COLLECTED: 04/20/09 AT 2342
RECEIVED: 04/21/09 AT 0029

STAINS AND PREPARATIONS
04/21/09 0106
FEW WBCS
MANY GRAM POSITIVE COCCI
FEW GRAM POSITIVE RODS
RARE GRAM NEGATIVE RODS
FINAL REPORT
04/24/09 1406
HEAVY GROWTH OF STAPHYLOCOCCUS AUREUS AND STREPTOCOCCUS PNEUMONIAE
SUSCEPTIBILITY TESTING

S AUREUS	MIC	INTERP
AZITHROMYCIN		S
CIPROFLOXACIN	<=0.5	S
CLINDAMYCIN	<=0.25	S
D-TEST	NEGATIVE	
ERYTHROMYCIN	<=0.25	S
LEVOFLOXACIN	<=0.12	S
OXACILLIN	0.5	S
SULFA/TRIMETH	<=10	S
TETRACYCLINE	<=1	S
VANCOMYCIN	<=0.5	S

S PNEUMO	MIC	INTERP
AMPICILLIN		S

RESPIRATORY CULTURES AND ASSOCIATED TESTS (Continued)

AZITHROMYCIN		S
CEFOTAX-MENING	<=0.06	S
CEFOTAX-NONMNG	<=0.06	S
CEFTRI-MENING	<=0.06	S
CEFTRI-NONMNG	<=0.06	S
CHLORAMPHENICOL	<=2	S
ERYTHROMYCIN	<=0.06	S
LEVOFLOXACIN	1	S
PENICILLIN G	<=0.06	S
SULFA/TRIMETH	<=10	S
TETRACYCLINE	<=1	S
VANCOMYCIN	<=1	S

DATE AND TIME OF REPORT: 04/24/2009 AT 1407

;

** Urine Culture 20APR2009 21:54 MCRO Final

W[redacted] N[redacted] G

URINE CULTURES AND ASSOCIATED TESTS

CULTURE, URINE
URINE, CATHETERIZED, FOLEY

ACCESSION #: PP-09-022971
COLLECTED: 04/20/09 AT 2154
RECEIVED: 04/20/09 AT 2251

FINAL REPORT
04/22/09 1019
NO GROWTH
DATE AND TIME OF REPORT: 04/22/2009 AT 1020

;

** Blood Cult (Aerobic) 20APR2009 15:35 MCRO Final

W[redacted] N[redacted] G

BLOOD CULTURES

CULTURE, BLOOD, AEROBIC
BLOOD OBTAINED BY VENIPUNCTURE

ACCESSION #: BL-09-023705
COLLECTED: 04/20/09 AT 1535
RECEIVED: 04/20/09 AT 1634

FINAL REPORT
04/26/09 1000
NO GROWTH 5 DAYS
DATE AND TIME OF REPORT: 04/26/2009 AT 1000

;

PATHOLOGY

PATHOLOGY REPORTS:
** No data matched **

MISC LABS

MISCELLANEOUS LAB RESULTS:

	7May2009	30Apr2009	29Apr2009	28Apr2009
	18:30	04:24	06:14	10:30
Misc Other Labs	FH	FH	FH	FH
	Final	Final	Final	Final

INOVA HEALTH SYSTEM

Requested by: PURKERT, KATHERINE

Patient	W[redacted] N[redacted] G.
MRN	04305493
DOB	[redacted]2008
Date of Service	
Performing Facility	FH
Ordering Provider	TOLBERT, CHARONE
Result Provider	
Report Name	MRI Brain WWO Contrast
Status	F DXSTIC X

EXAMINATION: MR3-0047 MRI BRAIN WWO CONT
Date of Service: 05/01/2009 14:38

INTERPRETATION:

CLINICAL HISTORY: 5-month-old male patient with nonaccidental trauma and seizures.

EXAM: On a 1.5 Tesla closed system, the brain was imaged utilizing multiple pulse sequences in orthogonal planes following the uneventful administration of intravenous gadolinium. Anesthesia and monitoring was provided by the Department of Anesthesia at Inova Fairfax Hospital.

Comparison made to most recent unenhanced CT head dated April 22, 2009.

FINDINGS:

There is now a T2 hyperintense subdural hygroma over the left frontal and ventral temporal convexity which has developed since the prior CT. This measures roughly 11 mm in thickness and produces mass effect on the left cerebral hemisphere, mild deformity on the left ventricular frontal horn and subtle left-to-right midline shift.

There is what appears to be a thrombosed cortical vein at the ventral left parietal convexity (best seen on series 3 images 1-9 and series 8 images 18-22). In that region of the parietal lobe there is some cortical laminar necrosis and enhancement which may reflect subacute venous ischemia from this thrombosed cortical vein. The flow-voids within the superior sagittal sinus and transverse/sigmoid sinuses are normal. There is patchy cortical enhancement involving the supratentorial hemispheres (to a greater degree in the bilateral occipital lobes and left parietal region) best seen on post contrast coronal series 10. This finding is nonspecific but probably reflects posttraumatic parenchymal injury as well. There is signal abnormality and restricted diffusion within the splenium which suggests axonal injury.

The subdural blood along the falx appears to have resolved. There is residual extra-axial subdural hemorrhage over the left occipital convexity and along the midline between the cerebellar hemispheres in the posterior fossa. Finally, the overall volume of the brain parenchyma is significantly less than on the prior CT. The patient is well-hydrated

INOVA HEALTH SYSTEM

Requested by: PURKERT, KATHERINE

Patient :W[redacted] N[redacted] G.
MRN :04305493
DOB [redacted]/2008
Date of Service :
Performing Facility :FH
Ordering Provider :TOLBERT, CHARONE
Result Provider :
Report Name :MRI Brain WWO Contrast
Status :F DXSTIC X

as per the clinical service. Findings may therefore reflect the actual baseline parenchymal brain volume with subsequent resolution of diffuse cerebral edema. Making this assumption, the volume is low which suggests malnourishment or failure to thrive.

The orbital contents are unremarkable. The optic chiasm, intracranial optic nerves and optic tracts are symmetric. The visualized paranasal sinuses are clear. There is scattered fluid middle ear cavities and mastoid air cells. There is moderate adenoidal and palatine tonsillar hypertrophy.

IMPRESSION:

1. Interval development of left frontal and anterior temporal subdural hygroma as described.
2. Thrombosed left parietal cortical vein with evidence of subjacent ischemia and laminar necrosis.
3. Patchy cortical enhancement involving the bilateral occipital and left parietal lobes suggesting parenchymal injury.
4. Signal abnormality and restricted diffusion in the splenium suggesting deep white matter and/or axonal injury.
5. Resolving subdural hemorrhages over the left occipital convexity and midline posterior fossa.
6. Significant reduction in parenchymal brain volume which may reflect resolution of diffuse cerebral edema on the initial unenhanced CT scans. Please see discussion above.

Findings were discussed by phone with Dr. Marimon of the pediatric inpatient service on May 1st 2009 at 4:30 p.m.

Dictating Physician: CHRISTIAN MULLER M.D.
Electronically Signed: 012654 on May 1 2009 5:05PM
Dictated: May 1 2009 5:07PM
Transcribed: on May 1 2009 5:05PM

INOVA FAIRFAX HOSPITAL

Admission Date: 4/20/2009 5:18 PM (ET)
Patient Name: W[redacted] N[redacted]
MRN: 04305493
Account Number: 037373672
Location: EDA / EDA-EDA-FEDA-03

CM Assessment: Daily/ Weekly Notes

Patient Information - MRN # 04305493 - W[redacted] N[redacted]

Name:	N[redacted] W[redacted]	**Admission Date:**	4/20/2009 5:18 PM (ET)
MRN:	04305493	**Account Number:**	037373672
Date of Birth:	[redacted]2008 (age 5 month(s))	**Social Security Number:**	
Gender:	Male	**Marital Status:**	Single
Primary Diagnosis:	TRAUMATIC SUBDURAL HEM	**Secondary Diagnosis:**	
Address:	[redacted] ALEXANDRIA, VA[redacted]	**Home:** **Work:** **Alternative:**	(571) 332-1201
Admitting Physician:	AGARWAL, SWATI	**Attending Physician:**	AGARWAL, SWATI
Readmit:	No	**Last Discharge Date:**	
Primary Plan Description:	BC CAREFIRST NCA 080	**Primary Plan Number:**	XIP901804718
Secondary Plan Description:		**Secondary Plan Number:**	

Assessment Notes - MRN # 04305493 - W[redacted] N[redacted]

Assessment Note Created By:	Rotondo, Donna	**Department:**	Case Management
Assessment Note Created On:	4/20/2009 6:03 PM (ET)		

Notes:

SOCIAL WORK

Request by ED Attending to refer case to CPS. Spoke with Fairfax County Police officer LD. Anderson who is present in hospital following case. Reports case being investigated---detectives at the scence currently. Officer reports not known if CPS contacted. Per protocol Fairfax County CPS (703 324-7400) contacted, spoke with intake worker Lou Phelps. Ms. Phelps reports case to be assigned to Jocelyn Waldron. PICU SW to follow for ongoing needs.

Signature: Donna M. Rotondo LCSW **Date Signed:** 4/20/2009

Signed by: Rotondo, Donna **Position:** Social Worker
Phone Number: (703) 776-3694 **Pager Number:** (301) 939-8146

ECIN Generated (Scan)

PICU Resident Progress Note

Tuesday, April 21, 2009

Name: W[redacted] N[redacted] Room: 501 Age: 4.5 months
DOB: [redacted]2008 MRN: 4305493 Admit Date: 4/20/2009
Wt: 6.8kg PICU admit: 4/20/2009

Problem List:
1. subdural hematoma
2. r/o NAT

Allergies: NKDA , NKFA

Lines/Tubes/Drains:
1. ETT, 3.5
2. OG to gravity
3. PIV

Neuro: intubated sedated in ED

Exam: nl tone, arousable, pinpoint pupils

1. Fentanyl 7 mcg IV q1 prn
2. Versed 1.2mg IV q1 prn
3. Fosphenytoin 20mg IV q12

Neuro - Assessment & Plan: subdural hematoma, r/o NAT
1. neurosurgery following
2. repeat CT head to follow up SDH (stable)
3. optho c/s to evaluate for retinal hemorrhages (called)

CVS
HR 130-190's BP: 80-100 / 50-60
MAP: 55-70 ~~CVP:~~

Exam: RRRS1S2 ✓M 2+ brachial pulses

1.
CVS - Assessment & Plan: stable
1. ø issues
2.

Pulmonary
SIMV Mode: ~~Control~~ PC: PS: 10 PEEP: 5 RR: 28 FIO2: 30%
RR: 25-40 Sats: 100% ETCO2 34-42

Exam: CTA(B) vented breaths

CXR: 4/20 ?6IL atelectasis vs infiltrate
ABG: / / / /

1.
Pulmonary - Assessment & Plan: intubated
1. extubate today → aggress b rate to keep FiCO2 <50
2. F/U CXR today (post extubation)

Infectious Disease
Temp: ~~98-101~~ 98°-101.3°

WBC: 635 | 14^B 17^L 6^M

Cultures: Blood cx 4/20, urine cx 4/20, sputum culture few WBC, many GPC, GNR rare, few GPR

1. CTX 340mg IV q24
2. Tylenol prn OG q4 fever

Infectious Disease - Assessment & Plan: consider meningitis
1. follow up cultures and continue Abx
2. if extubated and stable, consider LP

Heme:
8.5 / 10 / 25 / 271
13.7 | 33 / 1.2
Fibrinogen 290(H)

1.
2.
Heme – Assessment & Plan:
1. monitor H/H post bleed
2. based on CT findings, to decide if c/s neuro (not at this time)

FEN/GI:
IN/OUT: 549 / 267 Balance: ⊕ 282
UOP: ~~0.5~~ 5.8 mL/kg/hr (12hr) BM/Emesis: ø
Diet: NPO
IVF: NS @ 30cc/hr

Exam:
137 | 106 | 3 / 3.7 | 23 | 0.2 / 103 / 9.2

UA SG 1016 pH 5 glucose 250 ketones 15

1. ~~D5~~ NS @ 30cc/hr
FEN/GI - Assessment & Plan:
1. continue NPO and IVF at maintenance
2. follow accuchecks q4 and add D5 in fluids if BG < 100
3. accuchecks was BB so added D5 to fluids
4. once extubated, may monitor mental status and if awake advance feeds pedialyte then formula similac

Social: CPS called from ED, homicide detective involved, social work involved need Dr. Hauda consult

Assesment & Plan: possible NAT
1. skeletal survey today
2. called Dr. Hauda (aware)

Susan Mabrouk
Susan Mabrouk, M.D., P13755
4/21/20094/21/2009 7:36 AM

1PN

Date & Time	ALL ENTRIES	PHYSICIAN signature includes complete Name and ID#
DATE	TIME	

1225 4/21/09

Inova FACT Department

Chart Reviewed

Briefly – 4 mo b:ba from daycare yesterday w/ seizure after repeated choking episode, found to have SDH on CT scan.

Parents relate two injuries - wood plaque fell off wall while placing him into a bouncy chair ~10 days ago, small abrasion on back of head, seemed fine. Also had small (R) forehead bruise a few days later, told it was from thrashing on play mat @ daycare. Normal development with today, eating some solid foods, no medical problems.

(PE) Intubated, sedated (unable to do oral exam, will re-eval tomorrow), no visible external trauma.

(Rad) CT, (L) frontal SDH

Skeletal survey - pending.

(Opth) multiple, extensive (b) lateral retinal hemorrhages.

(SW) No acc'l dental trauma - shaking or shaking-impact most likely given SDH w/ RH. Need to exclude other occult trauma w/ bone survey.

(Rec) Disposition as per CPS/LE

Repeat skeletal survey in 10 days

No additional labs required at this time

will follow, call w/ questions

703 967 6798 #2912

DO NOT USE
U
QD
qd
IU
µg
QOD
QID/qid
AU
AS
AD
MS
MS04
MgSO4
AZT
Nitro drip

[redacted]
04305493 4M M
PADM ADM

G [redacted]08
FH 37373672
ACCT STRT

INOVA HEALTH SYSTEM
PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS-PROG

MED0527

PICU Resident Progress Note

Wednesday, April 22, 2009

Name: W[redacted], N[redacted] Room: 501 Age: 4.5 months
DOB: [redacted]2008 MRN: 4305493 Admit Date: 4/20/2009
Wt: 6.8kg PICU admit: 4/20/2009

Problem List:
1. subdural hematoma
2. ~~r/o~~ NAT
errors

Allergies: NKDA , NKFA

Lines/Tubes/Drains:
1. PIV

Neuro: optho c/s showed retinal hemorrhages
rash post Fosphenytoin
Exam: ni tone, arousable, pinpoint pupils

Head CT 4/21 stable SDH

1. Fentanyl 7 mcg IV q1 prn
2. Versed 1.2mg IV q1 prn
3. Fosphenytoin 20mg IV q12

errors

Neuro - Assessment & Plan: subdural hematoma, ~~r/o~~ NAT
1. neurosurgery following
2. 4/21/09 CT head to follow up SDH
3. optho c/s to evaluate for retinal hemorrhages extensive
4. ~~hold sedation for extubation~~ Neuro c/s → EEG

CVS
HR ~~140-180~~ BP: ~~70-100/40-60~~ 50's
MAP: ~~130-190~~ CVP:

Exam:

1.
CVS - Assessment & Plan: stable
1. no issues
2.

Phenytoin 5 mg/kg/dose 20-30 mg/kg load ± BID

Pulmonary. intubated 4/20- 4/21, stridor immediately post extubation
Racemic Epi x 1 dose 4/21, 1.5 LNC → RA 4pm 4/21

RR: ~~30-40~~ Sats: ~~100%~~ 95-100%
40-50's
Exam: stridor
CXR:
\BG: / / / /

1. Decadron 3.5 mg IV q6 x 24
Pulmonary - Assessment & Plan: racemic epi 9 2pm stridor 5 stridor
1. monitor stridor extubation

Infectious Disease
Temp:

WBC:

Cultures: Blood cx 4/20, urine cx 4/20 NGTD, sputum culture few WBC, many GPC, GNR

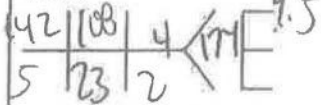
1. ~~CTX 340mg IV q24~~ D/C 4/21
2. Tylenol prn po q4 fever
Infectious Disease - Assessment & Plan:
1. follow up cultures
2.

Heme:

1.
2.
Heme – Assessment & Plan:
1. no issues

FEN/GI: 4/21 OG removed, advanced feeds 4/21
IN/OUT: ~~546/247~~ 967/549 Balance:
UOP: mL/kg/hr BM/Emesis:
Diet: Similac po ad lib
UA glucose 250, 15 ketones

Exam:



1. D5 NS @ ~~30~~ 15cc/hr
FEN/GI - Assessment & Plan:
1. HLIV today
2. follow accuchecks q4
3. repeat UA today prior to D/C foley

Social: CPS called from ED, homicide detective involved (confession from baby sitter who shook baby), social work involved, Dr. Hauda consulted

Assesment & Plan:
1. skeletal survey 4/22
transfer to floor today (Dr Chen)

Susan Mabrouk, M.D., P13755
4/22/20094/22/2009 7:46 AM

Pediatric ICU Attending Note
4/21/09 Time: 1240

W[redacted] N[redacted] G
MRN 4305493
DOB:[redacted]08

ID: 4.5 mo. male admitted with seizure after choking episode at daycare→Subdural hematoma
Interim history: Pt. waking up more overnight→requiring more sedation. Opening eyes, moving all extremities. Sucking on ETT. Repeat Head CT today with stable subdural hematoma. Stable on vent. +temp last night likely secondary to SDH. Optho eval today revealed bilateral retinal hemorrhages.

Images reviewed= Head CT today with stable posterior SDH, no mass effect.
Labs: Coags INR 1.3 Plt >100 Hct stable.
Numeric details per resident note.

PE: full
Intubated, AF- ~~soft~~. Pupils- dilated (after eye drops), +retinal hemorrhages bilat.
RRR –m/r/g Lungs- clear, no distress, symmetric chest wall movement, -flaring, -retr
Abd- soft, NT, ND +BS
Extr- warm, 2+ pulses, CRT < 2 sec. No deformities.
Skin- no bruising.

A/P: 4.5 mo. male with SDH, bilateral retinal hemorrhages consistent with NAI. Overall, pt. more active today. Will attempt extubation and then obtain skeletal survey.

- Neuro- On Fosphenytoin BID. Minimize sedation for extubation. NSurg following.
- CV- stable
- Resp- Wean vent rate today and attempt extubation if pt. ready.
- GI- NPO for now. Will have speech, PT, OT eval prior to PO feed trial after extub.
- Heme- Coags essentially normal, Plt ok. Will get further heme w/u if requested by Dr. Houda
- Dr. Houda consulted and involved. He will talk to detectives.
- Social- Both mom and dad and extended family updated on optho findings.

Swati Agarwal, MD Pager 13742

SA · 1 ms

INOVA FAIRFAX HOSPITAL

Admission Date: 4/20/2009 5:18 PM (ET)
Patient Name: W[redacted] N[redacted]
MRN: 04305493
Account Number: 037373672
Location: W5E / W5E-W501-FW501-01

CM Assessment: Daily/ Weekly Notes

Patient Information - MRN # 04305493 - W[redacted], N[redacted]

Name:	N[redacted] W[redacted]	**Admission Date:**	4/20/2009 5:18 PM (ET)
MRN:	04305493	**Account Number:**	037373672
Date of Birth:	[redacted]2008 (age 5 month(s))	**Social Security Number:**	
Gender:	Male	**Marital Status:**	Single
Primary Diagnosis:	TRAUMATIC SUBDURAL HEM	**Secondary Diagnosis:**	
Address:	[redacted] ALEXANDRIA, VA[redacted]	**Home:** **Work:** **Alternative:**	(571) 332-1201
Admitting Physician:	AGARWAL, SWATI	**Attending Physician:**	AGARWAL, SWATI
Readmit:	No	**Last Discharge Date:**	
Primary Plan Description:	BC CAREFIRST NCA 080	**Primary Plan Number:**	XIP901804718
Secondary Plan Description:		**Secondary Plan Number:**	

Assessment Notes - MRN # 04305493 - W[redacted] N[redacted]

Assessment Note Created By:	Sweatt, Layne	**Department:**	Case Management
Assessment Note Created On:	4/23/2009 11:58 AM (ET)		

Notes:

SOCIAL WORK NOTE

LATE ENTRY FOR 4/22/2009 (put into system on 4/23/209)

On 4/22/209, sw contacted Dr. Kronen regarding patient/family situation, requesting he see parents to provide additional evaluation,support and Interventions to them during this most difficult time. He indicated he would be in touch with parents.

SW met with mother on 4/22/2009, one-on-one, surrounding the events that have occurred. Encouraged her to express her feelings and to talk about the events as she understands them and her feelings as much as possible. SW also met with grandmother today, to provide additional support to her.

Will continue to monitor/follow this situation. This SW did not receive a phone call back from the Child Protective Services worker but will try to follow up again in this regard. SW has been told that daycare provider is being investigated/in custody.

Layne Sweatt, LCSW
x7968

Layne Sweatt 4/23/09

1PN

Date & Time	ALL ENTRIES	PHYSICIAN signature includes complete Name and ID#

DATE	TIME	
4/22/15	1445	EEG Completed : I. Hurley REGT For Results Call: 703-480-0956 Facility Code: 1100 User ID=99999 Press 2 Listen by Patient ID: Press 3 Enter Medical Record Number Multiple Records: Press 5 to Advance

CAT SCAN COMPLETED
DATE 4-22-15
TIME 1530
TECHNOLOGIST JP
EXAM Head

DO NOT USE

U
QD
qd
IU
µg
QOD
QID/qid
AU
AS
AD

MS
MS04
MgSO4
AZT

Nitro drip

PATIENT IDENTIFICATION

W[redacted]
N[redacted]
G[redacted]08
04305493 4M M FH 37373672
PADM ADM ACCT STRT

INOVA HEALTH SYSTEM
PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS-PROG

MED0533

Pediatric ICU Attending Note
4/22/09 Time: 1400

W[redacted] N[redacted] G
MRN 4305493
DOB: [redacted]08

ID: 4.5 mo. male admitted with seizure, SDH, retinal hemorrhages c/w NAI
Interim history: Extubated yesterday and breathing comfortably now on RA. Did have some transient stridor that improved after racemic epi. On Decadron x 4 doses now. No seizures o/n but is having some tonic activity today mostly right sided. Also captured on EEG. 13 min. of seizure activity stopped spontaneously—but Ativan given after. Dilantin level pending.

Images reviewed= none
Labs: Dilantin level pending.
Numeric details per resident note.

PE:
Intubated, AF- full, Pupils- reactive bilat. ? tracks to light.
RRR –m/r/g Lungs- clear, no distress, symmetric chest wall movement, -flaring, -retr
Abd- soft, NT, ND +BS
Extr- warm, 2+ pulses, CRT < 2 sec. No deformities.
Skin- no bruising.
Neuro- moving all 4 extr, ? decr mvt on right but IVs are in Right extremities. Seizure activity of tonic movement of right leg, arm, and right lip/cheek. No cyanosis or apnea.

A/P: 4.5 mo. male with SDH, bilateral retinal hemorrhages consistent with NAI. With seizures today. EEG in progress. Will check Dilantin level and consider re-load. Re-discuss changing to Keppra w/ Neuro.

- Neuro- F/U EEG. D/W AED treatment with Neuro.
- CV- stable
- Resp- Stable on RA. No desats with sz but will place NCO2 just in case.
- GI- PO improving. No signs of aspiration.
- Heme- stable.
- Dr. Houda consulted and involved. Awaiting skeletal survey.
- Social- Both mom and dad and extended family updated.

Swati Agarwal, MD Pager 13742

1PN

Date & Time		ALL ENTRIES PHYSICIAN signature includes complete Name and ID#
DATE	TIME	Nurses Note
4/23/09	0650	Pt c̄ seizure on (R) side of face c̄ mouth twitch and (R) leg twitch. Pt given Ativan x1 and Dr Baker @ bedside to assess pt. per Dr Grundl - phenobarbital 40mg given @ this time - cont to assess pt for seizure activity — [signature]
4/23/09	0700	Nursing Note Pt c̄ upper airway stridor - racemic epi given x1 will cont to assess pt resp status — [signature]
4/23/09	0800	Ped Neurology 1-2 minute (R) sided clonic Sz started yesterday late AM during the EEG recording. The EEG showed appropriate (L) hemisphere periodic activity during clinical events and gen'lzd slowing interictally. The Sz have increased in frequency through the night, resulting in incremental efforts to optimize the phenobarb levels, up to 27 ug/dl. But he still broke through. There are momentary times of decreased clinical Sz w/ intermittent Ativan use. IV loading of Keppra 20mg/kg has not decreased the Sz frequency. None last more than 2 min. Incremental loading doses of phenobarbital has been given just now complete the 2nd load of 5mg/kg, w/ some decrease of seizures. There are genuine attempts to avoid re-intubation. EXAM Shows good flexion posture of extr, symm resistance (mild) of all 4 extr, symm +1/2 DTRs, Toes [illegible]. Breathing spontaneously. Ant font still firm. IMP Recurrent Sz suspect underlying cerebral contusion not seen on serial head CT (cont'd →)

DO NOT USE: U, QD, qd, IU, µg, QOD, QID/qid, AU, AS, AD, MS, MS04, MgSO4, AZT, Nitro drip

W[redacted] N[redacted] G[redacted]08
04305493 4M M FH 37373672
PADM ADM ACCT STRT

INOVA HEALTH SYSTEM

PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS-PROG

MED0535

MR 8-00

1PN

Date & Time | ALL ENTRIES | PHYSICIAN signature includes complete Name and ID#

DATE	TIME	
4/23/09	0800	(cont'd — Ped Neurology)
		PLAN: 1/ Needs continuous EEG ASAP
		2/ Head MRI when stable
		3/ Probably needs more phenobarb & possible reintubation and supported ventilation
		4/ Phenobarb level after completion of 20 mg/kg load with the [illegible]
		5/ optimize levels to 25-35 µg/dl of the phenobarbital.
		[illegible signature] 1216
4/23/09	1058	Neurodiagnostic Department
		EEG electrodes applied with collodion in accordance to the Int 10-20 system. Continuous EEG already started without video cam per neurology request. Patient family and assigned nurse informed about pt event button.
		Michael Schuster
		R. [illegible], BS
4/23/2009	1214	Inova FACT Department
		Skeletal survey reviewed, minor abn @ distal (R) radius & ulna, no other apparent injuries, no conclusive trauma on survey, still recommend repeat skeletal survey around May 1st. This can be inpatient, or if pt has been d/c from hospital it will be arranged through the Inova FACT Department.
		Call w/ questions 703 967 6798
		[signature] #2912

DO NOT USE: U, QD, qd, IU, µg, QOD, QID/qid, AU, AS, AD, MS, MS04, MgSO4, AZT, Nitro drip

PATIENT IDENTIFICATION

[redacted] [redacted]

[redacted]

04305493 4M M FH 37373672

PADM ADM ACCT STRT

INOVA HEALTH SYSTEM

PATIENT PROGRESS NOTES

1PN

Date & Time		ALL ENTRIES PHYSICIAN signature includes complete Name and ID#
DATE	TIME	
		Neurosurg
4/23/09		99.7 90-100/50-60 110-180 Sat 100%
1130p		
		~~[illegible]~~
NS @ 30		pupil 2½ → 2 b/l
Keppra		MAE to stimuli
phenobarb		
Dilantin		
		A/P – 4 mth old ♂ c̄ bilat SDH
		1) Cont to follow neuro exam
		2) Treat seizure c̄ anticonvulsant per neurology
		3) No need for repeat CT scan unless change in exam
		[signature]
		6549
		[signature] 1740

DO NOT USE: U, QD, qd, IU, µg, QOD, QID/qid, AU, AS, AD, MS, MS04, MgSO4, AZT, Nitro drip

PATIENT IDENTIFICATION

W[redacted]
N[redacted]
G [redacted]/08
04305493 4M M FH 37373672
PADM ADM ACCT STRT

INOVA HEALTH SYSTEM

PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS-PROG

MED0537

PICU Resident Progress Note

Thursday, April 23, 2009

Name: W[redacted] N[redacted]
DOB: [redacted]2008
Wt: 6.8kg

Room: 501
MRN: 4305493

Age: 4.5 months
Admit Date: 4/20/2009
PICU admit: 4/20/2009

Problem List:
1. subdural hematoma
2. b/l retinal hemorrhages
3. NAT
4. Right focal seizures

Allergies: NKDA , NKFA

Lines/Tubes/Drains:
1. PIV

Neuro: optho c/s showed retinal hemorrhages, neuro c/s EEG and dilantin level, 4/22 right sided focal clonic movements

Exam: decreased tone, drowsy, pinpoint pupils, decreased mvt of R side > L

4/21 CT head stable SDH
4/22 CT head stable SDH
4/22 Dilantin levels 10, 27, EEG → ϕ subclinical seizures
4/23 Dilantin level 20, Phenobarbital 25 (nl)

1. Phenobarbital 10mg IV q12
2. Phenobarbital 40mg IV q1 hr x3, 35mg IV x1
3. Fentanyl 7 mcg IV q1 prn
4. Versed 1.2mg IV q1 prn

Neuro - Assessment & Plan: subdural hematoma, NAT
1. neurosurgery following-> no CTs needed,
2. neurology following-> continuous EEG, d/c Keppra and Fosphenytoin, PB level 4/24

CVS. 4/22 occasional bradycardia lasting few seconds
HR 110-160 BP: 90-100
50-70's

Exam:
RRR S1S2 no M 2+ brachial pulses

1.
CVS - Assessment & Plan: stable
1. monitor for bradycardia (? Possibly secondary to inc ICP).
2.

Pulmonary. intubated 4/20- 4/21, stridor immediately post extubation and received Racemic Epi, 4/23 HHNC due to apnea/resp distress

RR: Sats:

Exam: initially → nasal flaring supraclavicular retx
post HHNC → ϕ resp distress

CXR: 4/23 peripheral airspace opacities

1. Racemic Epi 11.25mg inh q2 prn stridor
2.

Pulmonary - Assessment & Plan: stridor post extubation, apnea
1. Monitor for resp distress esp while seizing

Infectious Disease
Temp: afebrile

WBC:

Cultures: Blood cx 4/20 NGTD, urine cx 4/20 negative, sputum culture heavy growth staph aureus (pan sensitive) and strep pneumoniae

1. Tylenol 100mg prn po/pr q4 fever

Infectious Disease - Assessment & Plan:
1. follow up blood culture
2.

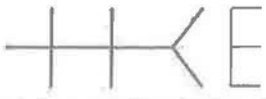
Heme: SDH stable

1.
2.
Heme – Assessment & Plan:
1. no active bleeding

FEN/GI: 4/21 OG removed, advanced feeds 4/21, on 4/22 NPO, MIVF, 4/23 NS bolus, ND placement and start feeds

IN/OUT: 840/972 Balance: -132
UOP: 6 mL/kg/hr BM/~~Emesis~~: x 2
Diet: Similac 20cal/oz ND
repeat UA 4/22 negative
KUB to follow up ND placement

Exam: Soft NT ND
NABS



1. D5 NS @ cc/hr

FEN/GI - Assessment & Plan:
1. weaning IVF to 15cc/hr then to 2cc/hr when place ND + T feeds
2. start Similac feeds at 5cc/hr then increase by 10cc/hr q2hr to goal of 30cc/hr (70 cal/kg/day = 106 cc/kg/day)
3. 4/24 AM labs: CMP

Social: CPS called from ED, homicide detective involved (confession from baby sitter who shook baby), social work + Dr. Hauda involved, Dr. Kronen consulted for mom

PMR: Speech: reassess when taking po, PT/OT recs: extensive therapy

Assesment & Plan: NAT, mom with anxiety
1. skeletal survey 4/22 negative for fractures
2. per FACT team, needs May 1st repeat skeletal survey (inpt/outpt)

PT/OT following

Susan Mabrouk, M.D., P13755
4/23/20094/23/2009 2:12 PM

INOVA FAIRFAX HOSPITAL

Admission Date: 4/20/2009 5:18 PM (ET)
Patient Name: W[redacted] N[redacted]
MRN: 04305493
Account Number: 037373672
Location: W5E / W5E-W501-FW501-01

CM Assessment: Daily/ Weekly Notes

Patient Information - MRN # 04305493 - W[redacted], N[redacted]

Name:	N[redacted] W[redacted]	**Admission Date:**	4/20/2009 5:18 PM (ET)
MRN:	04305493	**Account Number:**	037373672
Date of Birth:	[redacted]2008 (age 5 month(s))	**Social Security Number:**	
Gender:	Male	**Marital Status:**	Single
Primary Diagnosis:	TRAUMATIC SUBDURAL HEM	**Secondary Diagnosis:**	
Address:	[redacted] ALEXANDRIA, VA[redacted]	**Home:** **Work:** **Alternative:**	(571) 332-1201
Admitting Physician:	AGARWAL, SWATI	**Attending Physician:**	AGARWAL, SWATI
Readmit:	No	**Last Discharge Date:**	
Primary Plan Description:	BC CAREFIRST NCA 080	**Primary Plan Number:**	XIP901804718
Secondary Plan Description:		**Secondary Plan Number:**	

Assessment Notes - MRN # 04305493 - W[redacted], N[redacted]

Assessment Note Created By:	Sweatt, Layne	**Department:**	Case Management
Assessment Note Created On:	4/23/2009 11:58 AM (ET)		

Notes:

SOCIAL WORK NOTE

LATE ENTRY FOR 4/22/2009 (put into system on 4/23/209)

On 4/22/209, sw contacted Dr. Kronen regarding patient/family situation, requesting he see parents to provide additional evaluation,support and interventions to them during this most difficult time. He indicated he would be in touch with parents.

SW met with mother on 4/22/2009, one-on-one, surrounding the events that have occurred. Encouraged her to express her feelings and to talk about the events as she understands them and her feelings as much as possible. SW also met with grandmother today, to provide additional support to her.

Will continue to monitor/follow this situation. This SW did not receive a phone call back from the Child Protective Services worker but will try to follow up again in this regard. SW has been told that daycare provider is being investigated/in custody.

Layne Sweatt, LCSW
x7968

Layne Sweatt 4/23/09

INOVA FAIRFAX HOSPITAL

Admission Date: 4/20/2009 5:18 PM (ET)
Patient Name: W[redacted] N[redacted]
MRN: 04305493
Account Number: 037373672
Location: W5E / W5E-W501-FW501-01

Patient Information - MRN # 04305493 - W[redacted], N[redacted]

Name:	N[redacted] W[redacted]	**Admission Date:**	4/20/2009 5:18 PM (ET)
MRN:	04305493	**Account Number:**	037373672
Date of Birth:	[redacted]2008 (age 5 month(s))	**Social Security Number:**	
Gender:	Male	**Marital Status:**	Single
Primary Diagnosis:	TRAUMATIC SUBDURAL HEM	**Secondary Diagnosis:**	
Address:	[redacted] ALEXANDRIA, VA[redacted]	**Home:** **Work:** **Alternative:**	(571) 332-1201
Admitting Physician:	AGARWAL, SWATI	**Attending Physician:**	AGARWAL, SWATI
Readmit:	No	**Last Discharge Date:**	
Primary Plan Description:	BC CAREFIRST NCA 080	**Primary Plan Number:**	XIP901804718
Secondary Plan Description:		**Secondary Plan Number:**	

Assessment Notes - MRN # 04305493 - W[redacted], N[redacted]

Assessment Note Created By:	Ayoub, Linda	**Department:**	Case Management
Assessment Note Created On:	4/23/2009 10:40 AM (ET)		
Notes:			
Per resident's request, met with parents in early am of today due to parents fragile emotional status and anxiety surrounding their child's medical circumstances....psych consult ordered after parents agreed to meeting with psychiatrist this morning. Layne Sweatt, social worker, very involved with the family and offering support as needed. Linda A at 4113			

[signature]
(Linda Ayoub, MD)
4113

4/24/09
Case Mgr.

Pediatric ICU Attending Note
4/23/09 Time: 1400

W[redacted], N[redacted] G
MRN 4305493
DOB: [redacted]08

ID: 4.5 mo. male admitted with seizure, SDH, retinal hemorrhages c/w NAI with status epilepticus
Interim history: Right sided generalizing to left sided seizures overnight c/w status epilepticus. Dilantin, Keppra and phenobarb loads given. Dilantin level 27→20, phenobarb level 25 after 20 mg/kg this a.m. Cont. EEG in place. Pt with some stridor and retractions therefore placed on HHNC 8 lpm with improvement. Afebrile. No signif bradys. NPO.

Images reviewed= ? rml haziness
Labs: per HPI and resident note
Numeric details per resident note.

PE:
AF- full, Pupils- reactive bilat., sedated
RRR –m/r/g Lungs- clear, no distress, symmetric chest wall movement, -flaring, mild retr
Abd- soft, NT, ND +BS
Extr- warm, 2+ pulses, CRT < 2 sec. No deformities.
Skin- no bruising.
Neuro- somewhat hypertonic today in all extr, no clonus

A/P: 4.5 mo. male with SDH, bilateral retinal hemorrhages consistent with NAI. With status epilepticus--cont. EEG in progress. Neurology following and recommends Phenobarbital treatment with goal phenobarb level 25-30.

- Neuro- Cont. EEG. Phenobarb BID. Follow levels. Stop other AEDs. Ativan prn. Goal to control seizures today. Will need MRI when stable. PT/OT/Speech involved.
- CV- stable
- Resp- Improved on HHNC. Will intubate if necessary given side effects of sedation of AEDs.
- GI- Place ND tube and start feeds.
- Heme- stable.
- Dr. Houda consulted and involved. Skeletal survey negative, ? right wrist abnl. Repeat skeletal survey around May 1st.
- Social- Both mom and dad and extended family updated. Psych/SW/Case Mgt involved.

Swati Agarwal, MD Pager 13742

INOVA FAIRFAX HOSPITAL

Admission Date: 4/20/2009 5:18 PM (ET)
Patient Name: [redacted]
MRN: 04305493
Account Number: 037373672
Location: W5E / W5E-W501-FW501-01

Patient Information - MRN # 04305493 - [redacted]

Name:	[redacted]	**Admission Date:**	4/20/2009 5:18 PM (ET)
MRN:	04305493	**Account Number:**	037373672
Date of Birth:	[redacted]2008 (age 5 month(s))	**Social Security Number:**	
Gender:	Male	**Marital Status:**	Single
Primary Diagnosis:	TRAUMATIC SUBDURAL HEM	**Secondary Diagnosis:**	
Address:	[redacted] ALEXANDRIA, VA [redacted]	**Home:** **Work:** **Alternative:**	(571) 332-1201
Admitting Physician:	AGARWAL, SWATI	**Attending Physician:**	AGARWAL, SWATI
Readmit:	No	**Last Discharge Date:**	
Primary Plan Description:	BC CAREFIRST NCA 080	**Primary Plan Number:**	XIP901804718
Secondary Plan Description:		**Secondary Plan Number:**	

Assessment Notes - MRN # 04305493 - [redacted]

Assessment Note Created By:	Sweatt, Layne	**Department:**	Case Management
Assessment Note Created On:	4/24/2009 2:09 PM (ET)		

Notes:

SOCIAL WORK NOTE

4/24/2009 1400

SW left a message for Fairfax County Child Protective Services worker requesting an update on investigation/situation. Also, on the message, asked about any services (such as counseling) through victim services that might be available to this family.

SW continues to support family and follow this situation. Met with father who said that he and his wife continue to meet with Dr. Kronen, psychiatrist, and that this has been helpful. Mother more interactive, involved, and rested today, per father.

Layne Sweatt, LCSW
x7968

Layne Sweatt
7968 4/24/09

MED0542

1PN

Date & Time		ALL ENTRIES	PHYSICIAN signature includes complete Name and ID#
DATE	TIME		
		Neurosurgery	
9/23/09	11:00pm	Patient on continuous EEG monitoring and noted to have another seizure. Would recommend continued anticonvulsant treatment per neurology for seizures. No acute neurosurgical intervention at this time. Would get repeat Head CT if decline in neurologic exam noted. Call c̄ questions.	
		[signature] 61447	
9/24/09	1000	Ped Neurology	
		3 clinical seizures reported overnight, there were more than 6 electrographic Sz all looking similar on the EEG whether w/ clinical event or not. The electrographic Sz look like periodic epileptiform discharges of 1 Hz frequency — even w/ clinical Sz. ~~EXAM~~ The last seen was at 5 AM when the phenobarb level was 48 µg/dl.	
		EXAM Eyes opened, some recognition of parents, more interactive movements. ~~[illegible]~~ DTR. Pupils 4/4 → 2/2.	
		IMP Frequent prolonged seizures + subclinical & clinical lasting more than 15 min each despite high adequate phenobarb level.	
		SUGGEST 1/ Versed drip to burst suppression pattern x 24 hours minimum.	
		2/ Maintain phenobarb level 35-40	
		3/ Anticipate need for intubation.	
		4/ Will need head MRI when stable. [signature] 12/60	

DO NOT USE: U, QD, qd, IU, µg, QOD, QID/qid, AU, AS, AD, MS, MS04, MgSO4, AZT, Nitro drip

PATIENT IDENTIFICATION
W[redacted]
N[redacted]
G[redacted]08
4M M FH 37373672
ADM ACCT STRT
PADM

INOVA HEALTH SYSTEM
PATIENT PROGRESS NOTES

CAT # 84797A / R102408
IHS-MS-PROG

MED0543